Be prepared for 2021...

Office E/M Coding Changes

...learn how to navigate new CPT guidelines

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2021 Office E/M Coding Changes

Physicians and other practitioners who are paid under the Medicare Physician Fee Schedule (MPFS) bill for common office or other outpatient visits for evaluation and management (E/M) services using a set of Current Procedural Terminology (CPT)* codes that distinguish visits based on the level of complexity, site of service, and whether the patient is new (CPT codes 99201-99205) or established (CPT codes 99211-99215).

For the first time since it was introduced in 1992, the office/outpatient E/M CPT code set has been extensively revised, including the addition of a new code to report incremental time associated with prolonged office or other outpatient services.

Effective January 1, 2021, new reporting guidelines will be implemented and code selection for office/outpatient E/M services will be based on:

Medically Appropriate **History and/or Examination** + **Medical Decision Making** OR **Total Time on the Day of Encounter**

Have questions about office/outpatient E/M coding?

CONTACT THE ACS CODING HOTLINE

2021 Office/Outpatient E/M Visit Coding Changes

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2021 Code Descriptors

Descriptors and related elements for code selection for office/outpatient E/M visits have been updated for 2021.

Reporting Guidelines

New rules have been created for selecting and reporting office/outpatient E/M code levels.

History and Examination

History and physical examination requirements have been eased for office/outpatient E/M reporting.

Time

Total time on the date of the encounter may be used for office/outpatient E/M code selection.

Medical Decision Making (MDM)

The level of MDM for office/outpatient E/Ms is based on 2 out of 3 elements for both new and established patients.

ACS Advocacy

The ACS has engaged in extensive advocacy efforts related to E/M changes.

2021 E/M Codes

2021 E/M CODES

2021 E/M Office/Outpatient Visit CPT Codes

The table below highlights the changes to the office/outpatient E/M code descriptors for 2021.

CPT CODE	CODE DESCRIPTOR PRIOR TO 2021	CODE DESCRIPTOR BEGINNING IN 2021
New Patient		
99201	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; **Straightforward medical decision making**. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, **10 minutes are spent face-to-face** with the patient and/or family.	This code has been **deleted**. To report, use 99202.
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; **Straightforward medical decision making**. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, **20 minutes are spent face-to-face** with the patient and/or family.	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and **straightforward medical decision making**. When using time for code selection, **15-29 minutes of total time** is spent on the date of the encounter).
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; **Medical decision making of low complexity**. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, **30 minutes are spent face-to-face** with the patient and/or family.	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and **low level of medical decision making**. When using time for code selection, **30-44 minutes of total time** is spent on the date of the encounter.
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; **Medical decision making of moderate complexity**. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, **45 minutes are spent face-to-face** with the patient and/or family.	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and **moderate level of medical decision making**. When using time for code selection, **45-59 minutes of total time** is spent on the date of the encounter.

2021 E/M Codes

CPT CODE	CODE DESCRIPTOR PRIOR TO 2021	CODE DESCRIPTOR BEGINNING IN 2021
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; **Medical decision making of high complexity**. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, **60 minutes are spent face-to-face** with the patient and/or family.	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and **high level of medical decision making**. When using time for code selection, **60-74 minutes of total time** is spent on the date of the encounter.
Established Patient		
99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not **require the presence of a physician** or other qualified health care professional. Usually, the **presenting problem(s) are minimal**. Typically, 5 minutes are spent performing or supervising these services.	Office or other outpatient visit for the evaluation and management of an established patient, that **may not require the presence of a physician** or other qualified health care professional. Usually, the **presenting problem(s) are minimal**.
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; **Straightforward medical decision making**. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, **10 minutes are spent face-to-face** with the patient and/or family.	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and **straightforward medical decision making**. When using time for code selection, **10-19 minutes of total time** is spent on the date of the encounter.
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; **Medical decision making of low complexity**. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, **15 minutes are spent face-to-face** with the patient and/or family.	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and **low level of medical decision making**. When using time for code selection, **20-29 minutes of total time** is spent on the date of the encounter.
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; **Medical decision making of moderate complexity**. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, **25 minutes are spent face-to-face** with the patient and/or family.	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and **moderate level of medical decision making**. When using time for code selection, **30-39 minutes of total time** is spent on the date of the encounter.

2021 E/M Codes

CPT CODE	CODE DESCRIPTOR PRIOR TO 2021	CODE DESCRIPTOR BEGINNING IN 2021
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; **Medical decision making of high complexity**. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, **40 minutes are spent face-to-face** with the patient and/or family.	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and **high level of medical decision making**. When using time for code selection, **40-54 minutes of total time** is spent on the date of the encounter. *(For services 55 minutes or longer, see Prolonged Services 99XXX)*
New or Established Patient		
HCPCS code G2212*	N/A—this code is new for 2021.	**Prolonged** office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; **each additional 15 minutes** by the physician or qualified healthcare professional, with or without direct patient contact *(List separately in addition to CPT codes 99205, 99215 for office or other outpatient evaluation and management services) (Do not report G2212 on the same date of service as 99354, 99355, 99358, 99359, 99415, 99416). (Do not report G2212 for any time unit **less than 15 minutes**).*

*__IMPORTANT NOTE:__ The new, shortened prolonged services code HCPCS code G2212 will NOT BE EFFECTIVE UNTIL 2021; ***do not use this new code for services prior to January 1, 2021.***

More details about these office/outpatient E/M changes can be found at CPT® Evaluation and Management (E/M) Office or Other Outpatient (99202-99215) and Prolonged Services (99354, 99355, 99356, 99XXX) Code and Guideline Changes.

Reporting Guidelines

GUIDELINES FOR E/M REPORTING

Documentation requirements for E/M visits will also be revised to include **two separate sets of reporting guidelines:**

- One set for reporting office/outpatient E/M visits
- One set for reporting all other E/M visits that are not furnished in the office/outpatient setting

The table below highlights several major differences in reporting guidelines for E/M visits effective January 1, 2021.

	OFFICE/OUTPATIENT E/M VISITS (99202-99205, 99211-99215, G2212)	**ALL OTHER E/M VISITS (e.g., consultation, inpatient, observation, nursing home, emergency department visits)**
Which reporting guidelines apply to E/M services in 2021?	**New:** Code selection is based on medical decision making **OR** total time on the date of encounter.	**No change:** The 1995 and 1997 E/M documentation guidelines continue to apply to all other E/M services not furnished in the office or other outpatient setting.
Are history and physical examination (H&P) required elements?	**New:** History **and/or** examination is required **only** as medically appropriate for all levels of both new and established patient codes.	**No change:** The four categories of H&P (problem focused, expanded problem focused, detailed, and comprehensive) are **still applicable** in E/M code selection.
When using TIME for reporting, how is time used for code selection?	**New:** Code selection is based on **total face-to-face and non-face-to-face time** of the billing provider on the date of the encounter.	**No change:** Time may only be used for code selection when **counseling and/or coordination of care** dominates the service.
When using MDM for reporting, what MDM elements apply for code selection?	**New:** Both new and established patients require only **two out of three** MDM components.	**No change:** Code selection for new patients requires **three out of three** MDM components. Code selection for established patients requires **two out of three** MDM components.

History and Examination

HISTORY AND EXAMINATION

Documenting H&P for Office/Outpatient E/M Services

Beginning January 1, 2021, only a **"medically appropriate history and/or examination"** will be required for all office/outpatient E/M codes. The number of body systems/areas reviewed and examined need only be performed and documented when medically necessary and clinically appropriate. This element of reporting was revised by CMS for Medicare patients in an effort to reduce documentation burden.

Additionally, for Medicare patients, billing practitioners **do NOT need to re-enter information** about a patient's chief complaint and history in the medical record that has already been entered by ancillary staff or the beneficiary. The billing practitioner may simply indicate in the medical record that such information was reviewed and verified. **Note that this policy may be different for non-Medicare private payors.**

The table below compares required H&P elements in the current and new CPT code set for the office/outpatient E/M codes.

	CPT CODE	H&P ELEMENTS PRIOR TO 2021	H&P ELEMENTS EFFECTIVE IN 2021
New Patient Codes*	**99202**	Expanded problem focused history/examination	***Medically appropriate*** history and/or examination for all codes
	99203	Detailed history/examination	
	99204	Comprehensive history/examination	
	99205	Comprehensive history/examination	
Established Patient Codes**	**99212**	Problem focused history/examination	
	99213	Expanded problem focused history/examination	
	99214	Detailed history/examination	
	99215	Comprehensive history/examination	

*Code 99201 will be deleted in 2021 and is not included in this table.

**Codes 99211 and G2212 are not included in this table because H&P elements do not apply.

Time

TIME

Beginning in 2021, total time on the date of the encounter may be used **instead** of MDM for office/outpatient EM code selection. Time has been redefined from "typical face-to-face time" to the sum of **both** face-to-face and non-face-to-face services of the physician or QHP on the date of the encounter. In addition, time may be used to select a code level for office/outpatient EM services **whether or not** counseling and/or coordination of care dominates the service.

The table below highlights the changes in time reporting requirements for office/outpatient E/M codes.

	CPT CODE	REPORTING TIME PRIOR TO 2021	REPORTING TIME EFFECTIVE IN 2021
New Patient	**99201**	Typically, 10 minutes are spent face-to-face with the patient and/or family	*Deleted for 2021*
	99202	Typically, 20 minutes are spent face-to-face with the patient and/or family	15-29 minutes total time on day of encounter
	99203	Typically, 30 minutes are spent face-to-face with the patient and/or family	30-44 minutes total time on day of encounter
	99204	Typically, 45 minutes are spent face-to-face with the patient and/or family	45-59 minutes total time on day of encounter
	99205	Typically, 60 minutes are spent face-to-face with the patient and/or family	60-74 minutes total time on day of encounter
	+G2212	New for 2021	Each additional 15 minutes after 74 minutes on day of encounter
Established Patient	**99211**	Typically, 5 minutes are spent performing or supervising these services	Time does not apply
	99212	Typically, 10 minutes are spent face-to-face with the patient and/or family	10-19 minutes total time on day of encounter
	99213	Typically, 15 minutes are spent face-to-face with the patient and/or family	20-29 minutes total time on day of encounter
	99214	Typically, 25 minutes are spent face-to-face with the patient and/or family	30-39 minutes total time on day of encounter
	99215	Typically, 40 minutes are spent face-to-face with the patient and/or family	40-54 minutes total time on day of encounter
	+G2212	New for 2021	Each additional 15 minutes after 54 minutes on day of encounter

Time

Examples of Using Time for Code Selection Beginning in 2021

The following clinical scenarios provide examples of using time for reporting an office visit for an established patient with a new 2-cm lump on the lower back.

Scenario A: On the day of the visit, Dr. Smith spends 5 minutes reviewing a patient's chart while clinical staff gowns the patient and takes vitals. Dr. Smith then spends 15 minutes updating the patient's history and performing a brief examination of the patient's back. Based on a review of the chart and the H&P, Dr. Smith determines the lump is a lipoma that does not require treatment. After the patient leaves the office, Dr. Smith completes the notes about the visit in the patient's chart. Dr. Smith spent a total of 25 minutes in face-to-face and non-face-to-face E/M services related to this patient encounter on the day of the visit. If time were used for code selection, Dr. Smith would report CPT code 99213 (i.e., 20-29 minutes total time), even though the presenting problem was minor and required no treatment.

Scenario B: On the day of the visit, Dr. Smith spends 5 minutes reviewing a patient's chart while clinical staff gowns the patient and takes vitals. In this scenario, the patient is obese and has limited mobility. It takes Dr. Smith a few extra minutes to position the patient for an examination of the lower back and then reposition him to sitting. The patient also has limited English proficiency and his son who came with the patient helps with translation. This results in Dr. Smith spending 20 minutes face-to-face with the patient. Based on a review of the chart and the H&P, Dr. Smith determines the lump is a lipoma that does not require treatment. After the patient leaves the office, Dr. Smith completes the notes about the visit in the patient's chart. In this scenario, Dr. Smith spent a total of 30 minutes in face-to-face and non-face-to-face E/M services related to this patient encounter on the day of the visit. If time were used for code selection, Dr. Smith would report CPT code 99214 (i.e., 30-39 minutes total time), even though the presenting problem was minor and required no treatment.

Medical Decision Making

MEDICAL DECISION MAKING

Levels of MDM

The original four **levels** of MDM (straightforward, low, moderate, and high) have not changed for 2021. However, as codes 99201 and 99202 previously both described "straightforward" MDM and were differentiated only by history and/or exam elements, code 99201 will be deleted and E/M services previously reported using 99201 will be reported using 99202 beginning in 2021.

The table below shows the level of MDM for each office/outpatient E/M code.

OFFICE/OUTPATIENT E/M CODE		LEVEL OF MDM
New Patient	**Established Patient**	
99201	**99211**	99201: Code deleted for 2021
		99211: MDM does not apply
99202	**99212**	Straightforward
99203	**99213**	Low
99204	**99214**	Moderate
99205	**99215**	High

Elements of MDM

Each level of MDM continues to have the same three elements. For 2021, the titles of these three MDM elements have been revised to better reflect the medical decision making process. The table below highlights the revisions to the MDM elements titles effective January 1, 2021, for office/outpatient E/M codes.

MDM ELEMENT TITLES	
Prior to 2021	**Effective in 2021**
1. Presenting Problem(s)	1. Number and Complexity of Problems Addressed
2. Diagnostic Procedure(s) Ordered	2. Amount and/or Complexity of Data to be Reviewed and Analyzed
3. Management Options Selected	3. Risk of Complications and/or Morbidity or Mortality of Patient Management

Medical Decision Making

Elements of MDM *(continued)*

Beginning in 2021, for **both** new and established patients, the level of MDM for office/outpatient E/Ms is based on 2 out of 3 elements. This differs from the current guidelines, which require 3 out of 3 elements for new patients.

Element 1: This element accounts for the disease, condition, illness, injury, symptom, sign, finding, complaint, or other matter addressed at the encounter, with or without a diagnosis being established.

Element 2: This element accounts for the amount and/or complexity of data to be reviewed and analyzed—it recognizes each unique test, order, or document to meet the requirements for each level of MDM.

Element 3: This element accounts for the risk of complications and/or morbidity or mortality of patient management, including complications associated with additional diagnostic testing or treatment.

Element 1: Problems Addressed

ELEMENT 1: PROBLEMS ADDRESSED

1. The number and complexity of problem(s) addressed.

CPT defines a **problem** as "...a disease, condition, illness, injury, symptom, sign, finding, complaint, or other matter addressed at the encounter, with or without a diagnosis being established at the time of the encounter."

Office/Outpatient E/M CPT Code	1) Number and Complexity of Problems Addressed
99211	**Not applicable**
99202 **99212**	**Minimal** 1 self-limited or minor problem
99203 **99213**	**Low** 2 or more self-limited or minor problems; -or- 1 stable chronic illness; -or- 1 acute, uncomplicated illness or injury
99204 **99214**	**Moderate** 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; -or- 2 or more stable chronic illnesses; -or- 1 undiagnosed new problem with uncertain prognosis; -or- 1 acute illness with systemic symptoms; -or- 1 acute complicated injury
99205 **99215**	**High** 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; -or- 1 acute or chronic illness or injury that poses a threat to life or bodily function

Element 2: Data Reviewed and Analyzed

ELEMENT 2: DATA REVIEWED AND ANALYZED

2. The amount and/or complexity of data to be reviewed and analyzed.

This element recognizes **each** unique test, order, or document to meet the requirements for each level of MDM. Tests can include imaging, laboratory, psychometric, or physiologic data. The difference between single or multiple **unique tests** is based on the applicable CPT code(s) for such tests. For example, CPT code 80047 describes a clinical laboratory panel that includes and requires multiple tests but is considered a single test because only one CPT code is reported.

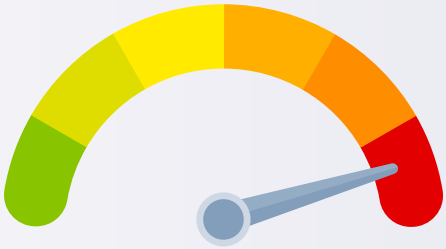
Important for surgeons: Independent interpretation of a test performed by another physician and not separately reported by the surgeon (e.g., independent interpretation of a chest x-ray) meets a criterion for this element as "data analyzed." In addition, discussion of patient management (e.g., surgeon and physical therapist) or test interpretation with external physicians (e.g., surgeon and pathologist) meets a criterion for this element. However, external physicians cannot be in the same group practice or same specialty/subspecialty as the billing surgeon. For example, reviewing an image with your office partner would not count as a criterion for this element.

Office/Outpatient E/M Visit CPT Code	2) Amount and/or Complexity of Data to be Reviewed and Analyzed
99211	**Not applicable**
99202 **99212**	**Minimal or none**
99203 **99213**	**Limited** *(Must meet the requirements of at least **1 out of 2** categories)* **Category 1: Tests and documents** Any combination of 2 from the following: • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test* -or- **Category 2: Assessment requiring an independent historian(s)** *(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)*

Element 2: Data Reviewed and Analyzed

Office/Outpatient E/M Visit CPT Code	2) Amount and/or Complexity of Data to be Reviewed and Analyzed
99204 **99214**	**Moderate** *(Must meet the requirements of at least **1 out of 3** categories)* **Category 1: Tests, documents, or independent historian(s)** Any combination of 3 from the following: • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; » Ordering of each unique test*; • Assessment requiring an independent historian(s) -or- **Category 2: Independent interpretation of tests** Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported) -or- **Category 3: Discussion of management or test interpretation** Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
99205 **99215**	**Extensive** *(Must meet the requirements of at least **2 out of 3** categories)* **Category 1: Tests, documents, or independent historian(s)** Any combination of 3 from the following: • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; » Ordering of each unique test*; • Assessment requiring an independent historian(s) -or- **Category 2: Independent interpretation of tests** Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported) -or- **Category 3: Discussion of management or test interpretation** Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)

Element 3: Risk



ELEMENT 3: RISK

3. The risk of complications and/or morbidity or mortality of patient management.

CPT has developed an extensive definition for risk:

> *"The probability and/or consequences of an event. The assessment of the level of risk is affected by the nature of the event under consideration. For example, a low probability of death may be high risk, whereas a high chance of a minor, self-limited adverse effect of treatment may be low risk. Definitions of risk are based upon the usual behavior and thought processes of a physician or other qualified health care professional in the same specialty. Trained clinicians apply common language usage meanings to terms such as 'high,' 'medium,' 'low,' or 'minimal' risk and do not require quantification for these definitions, (though quantification may be provided when evidence-based medicine has established probabilities). For the purposes of medical decision making, level of risk is based upon consequences of the problem(s) addressed at the encounter when appropriately treated. Risk also includes medical decision making related to the need to initiate or forego further testing, treatment and/or hospitalization."*

The MDM table provides examples of risk for moderate and high MDM that many surgeons can relate to, such as a decision regarding minor surgery **with** identified patient or procedure risk factors or a decision regarding elective major surgery **without** identified patient or procedure risk factors.

Office/Outpatient E/M Visit CPT Code	3) Risk of Complications and/or Morbidity or Mortality of Patient Management
99211	**Not applicable**
99202 **99212**	**Minimal risk of morbidity from additional diagnostic testing or treatment**
99203 **99213**	**Low risk of morbidity from additional diagnostic testing or treatment**
99204 **99214**	**Moderate risk of morbidity from additional diagnostic testing or treatment** *Examples only:* • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health
99205 **99215**	**High risk of morbidity from additional diagnostic testing or treatment** *Examples only:* • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization • Decision not to resuscitate or to de-escalate care because of poor prognosis

Regulatory History and Advocacy

REGULATORY HISTORY AND ADVOCACY

1992	1995	1997	2017	2018–2020	2021
Quantitiative E/M Codes Implemented by CPT	E/M Documentation Guidelines Released	E/M Documentation Guidelines Revised	CMS Solicits Stakeholder Feedback to Update Office/ Outpatient E/M Documentation Guidelines	CMS Finalizes Changes to Office/ Outpatient E/M Coding and Billing Rules	New Office/Outpatient E/M Codes and Documentation Guidelines Implemented by CPT

Medicare Physician Fee Schedule (MPFS) Rulemaking Process

July 2017—CY 2018 MPFS Proposed Rule

CMS requested stakeholder feedback on how to reform the E/M documentation guidelines, reduce associated burden, and better align E/M coding and documentation with the current practice of medicine. The Agency specifically sought comment on whether it would be appropriate to remove its documentation requirements for the H&P exam for all E/M visits at all levels, and also considered eventually allowing MDM and/or time to serve as the key determinant of E/M visit level.

The ACS agreed with CMS that the E/M documentation guidelines should be modified, noting that the current system requires unnecessary documentation, sometimes obscuring relevant and necessary information for patient care. However, the ACS did not support removing documentation requirements for the H&P exam for all E/M visits at all levels and recommended that CMS engage in a process to examine ways to streamline the H&P exam documentation requirements. In addition, the ACS opposed the use of time as the key determinant of E/M visit level—the College stated that using time alone is not appropriate because levels of medical decision-making can be different for different clinicians (for example, a physical therapist compared to a vascular surgeon), and although time is relevant and important to the assessment, medical decision-making is the most essential. The ACS urged CMS to explore the role of medical complexity, risk of medical decision-making, and other factors that incorporate aspects of the patient's overall state of health into a new weighting of the E/M documentation requirements.

→ Read the ACS' comments to the CY 2018 MPFS proposed rule

Regulatory History and Advocacy

November 2018—CY 2019 MPFS Final Rule

CMS finalized changes to the payment rates for E/M codes in 2021. For office/outpatient visits, CMS intended to combine E/M levels 2, 3, and 4 for new patients into a single payment rate and will combine E/M levels 2, 3, and 4 for established patients into a separate single payment rate. CMS also created additional add-on codes for primary care and certain specialized services.

The ACS did not support the collapse of work RVU values into one single rate under the MPFS because this amount is based on a calculation of several values, and CMS offered no assurance that the underlying math used to derive this single value correctly reflects the resources used to deliver care across the spectrum of U.S. health care professionals. Furthermore, a number of other unknowns remained with regard to this policy, such as how the single payment rate for levels 2 through 5 would affect physicians compensated through RVU-based payment structures. **The ACS also opposed the finalized add-on codes for primary care and certain specialty care services**, which would apply to specific specialties rather than the overall care of complex patients. Consequently, such codes would result in increased payment to certain specialties but not others that provide the same services.

➔ **Read the ACS' comments to the CY 2019 MPFS final rule**

November 2019—CY 2020 MPFS Final Rule

CMS finalized new changes to its coding and reimbursement policies for office/outpatient evaluation and management (E/M) visits to align with those developed by the American Medical Association (AMA) Current Procedural Terminology (CPT) Editorial Panel. Beginning in CY 2021, the Agency will **retain the five-level office/outpatient E/M coding system for established patients and reduce the number of levels to four for new patient visits**. CMS will adopt revised E/M code definitions created by the CPT Editorial Panel, which eliminate history and physical exam as elements for E/M code selection and allow physicians to choose the E/M visit level based on the extent of their medical decision making or on time spent with the patient.

Additionally, CMS accepted the AMA Specialty Society Relative Value Scale Update Committee's (RUC)-recommended payment rates for office/outpatient E/Ms for CY 2021, which will increase the values of most of these services. However, **the Agency will not apply such increases to postoperative E/M visits that are bundled into 10- and 90-day global surgical packages**.

The ACS commented extensively on this proposal and expressed its opposition to CMS' failure to apply increases to standalone office/outpatient E/Ms to global surgical packages. The College's comments stressed that this revaluation will disrupt the relativity of the MPFS because it will increase payment to certain specialties but not to others that provide the same services. CMS' policy also will pay different specialties different amounts for the same work, which is prohibited by law. In addition, the Agency ignored the recommendations of nearly all medical specialties when this policy was discussed at the RUC, which voted overwhelmingly to recommend that the full increase of work and physician time for standalone office/outpatient E/Ms be included in global codes. The College does not support any policies that unfairly result in lower reimbursement for surgeons and has continued to contest CMS' failure to increase values for the E/M portion of 10- and 90-day global surgical packages.

➔ **Read the ACS' comments to the CY 2020 MPFS final rule**